Exhibit "A-1"

[Limited Authorization to Disclose Health Information Pursuant to HIPAA]

LIMITED AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Excluding Psychiatric, Psychological, and Mental Health Treatment Notes/Records)
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

In re: Social Media Adolescent Addiction/Personal Injury Products Liability Litigation
Case No. 4:22-MD-03047-YGR, MDL No. 3047
United States District Court for the Northern District of California

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Patient | Date of Birth | Social Security Number

This will authorize you to furnish to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas 77043,** complete copies of the following records and/or information for the time period from _____ to the present:

All medical records and information (including those that may include protected health information) regarding the individual identified by name, DOB and Social Security number above, including relating to inpatient, outpatient, and emergency room treatment. Such records and information include, but are not limited to, all questionnaires/histories; clinical charts and/or reports; order sheets; progress notes; physician's notes; nurse's notes; physician's assistant's notes; social worker's notes; admission records; discharge summaries; requests for and reports of consultations; patient consent forms; copies (not originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy studies, films or imaging and corresponding reports; laboratory, pathology, histology, cytology, and autopsy reports; test results; records of drug and/or alcohol abuse; correspondence, emails, logs, pathology slides, H&P's, patient intake forms, insurance records, claim forms, and records received from other health professionals.

All pharmacy/prescription records, including NDC numbers and drug information handouts/monographs.

All billing records, including statements of account, itemized bills, invoices and insurance records.

Notwithstanding the broad scope of the above disclosure requests, the undersigned does not authorize the disclosure of notes or records pertaining to psychiatric, psychological, or mental health treatment or diagnosis as such terms are defined by HIPAA, 45 CFR § 164.501. However, a separate authorization may accompany this authorization for the release of psychological, psychiatric, and/or mental health records and information.

1. To my medical provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing, please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.**

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas 77043**. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or**

human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.

Name of Patient	Name of Patient's Representative (if applicable)
Former/Alias/Maiden Name of Patient	Description of Authority to Act for Patient
Address of Patient	Signature of Patient or Representative
Date	

Exhibit "A-2"

[Limited Authorization to Disclose Psychological, Psychiatric and Other Mental Health Information]

LIMITED AUTHORIZATION TO DISCLOSE PSYCHOLOGICAL, PSYCHIATRIC AND OTHER MENTAL HEALTH INFORMATION

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

In re: Social Media Adolescent Addiction/Personal Injury Products Liability Litigation
Case No. 4:22-MD-03047-YGR, MDL No. 3047
United States District Court for the Northern District of California

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Patient | Date of Birth | Social Security Number

This will authorize you to furnish to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas 77043,** complete copies of the following records and/or information for the time period from _____ to the present:

All psychological, psychiatric, and/or mental health records and information (including those that may contain protected health information) regarding the individual identified by name, DOB, and Social Security number above, including relating to inpatient, outpatient and/or emergency room treatment. Such records include, but are not limited to, questionnaires/histories; clinical charts and/or reports; order sheets; progress notes; psychiatric records; psychological records; psychotherapy notes; physician's notes; nurse's notes; physician assistant's notes; therapist, counselor or social worker's notes; treatment plans; admission records; discharge summaries; requests for and reports of consultations; patient consent forms; copies (not originals) of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy studies, films or imaging and corresponding reports; laboratory reports; test results; records of drug and/or alcohol abuse; correspondence, emails, logs, H&P's, patient intake forms, insurance records, claim forms, and records received from other health professionals.

All "psychotherapy notes," as such term is defined by the Health Insurance Portability and Accountability Act, 45 CFR § 164.501. Under HIPAA, the term "psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's record. This authorization does not authorize ex parte communication concerning same.

All pharmacy and prescription records, including NDC numbers and drug information handouts/monographs.

All billing records, including statements of account, itemized bills, invoices, and insurance records.

1. To records provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing, please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.**

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas 77043**. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome**

(AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.

Name of Patient	Name of Patient's Representative (if applicable)
Former/Alias/Maiden Name of Patient	Description of Authority to Act for Patient
Address of Patient	Signature of Patient or Representative
Date	

Exhibit "B"

[Authorization to Disclose Employment Records]

AUTHORIZATION TO DISCLOSE EMPLOYMENT RECORDS

In re: Social Media Adolescent Addiction/Personal Injury Products Liability Litigation
Case No. 4:22-MD-03047-YGR, MDL No. 3047
United States District Court for the Northern District of California

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Employee Date of Birth Social Security Number

This will authorize you to furnish to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas 77043,** complete copies of the following records and/or information for the time period from _____ to the present:

All applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files; all hospital, physician, clinic, infirmary, nurse, psychiatric and dental records; test results, physical examination records and other medical records; any records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports; insurance claim forms, questionnaires and records of payments made; pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; materials safety data sheets, chemical inventories and environmental monitoring records and all other employee exposure records pertaining to all positions held; and any other records concerning employment with the above-named entity.

1. To records provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing, please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.**

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas 77043**. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this employment/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure employment, employment benefits, or employment accommodations, or to assure medical treatment. I understand that the entity to whom this authorization is directed may not condition medical treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my employment and health records may include information relating to (a) psychiatric, psychological, or mental health information, and (b) to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.**

Name of Employee	Name of Employee's Representative (if applicable)
Former/Alias/Maiden Name of Employee	Description of Authority to Act for Employee
Address of Employee	Signature of Employee or Representative
Date	

Exhibit "C"

[Authorization for Release of Workers' Compensation Records]

AUTHORIZATION FOR RELEASE OF WORKERS COMPENSATION RECORDS

In re: Social Media Adolescent Addiction/Personal Injury Products Liability Litigation
Case No. 4:22-MD-03047-YGR, MDL No. 3047
United States District Court for the Northern District of California

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Worker | Date of Birth | Social Security Number

This will authorize you to furnish to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas 77043,** complete copies of the following records and/or information for the time period from _____ to the present:

All Workers' Compensation claims, including claim petitions, judgments, findings, notices of hearings, hearing records, transcripts, decisions and orders; all depositions and reports of witnesses and expert witnesses; employer's accident reports; all other accident, injury, or incident reports; all medical records; records of compensation payment made; investigatory reports and records; applications for employment; records of all positions held; job descriptions of any positions held; salary records; performance evaluations and reports; statements and comments of fellow employees; attendance records; all physicians', hospital, medical, health reports; physical examinations; records relating to health or disability insurance claims, including correspondence, reports, claim forms, questionnaires, records of payments made to physicians, hospitals, and health institutions or professionals; statements of account, itemized bills or invoices; and any other records relating to the above-named individual. Copies, NOT originals, of all x-rays, CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films and of any corresponding reports.

1. To records provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing,**

please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas 77043**. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this workers' compensation/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure employment, employment benefits, or employment accommodations, or to assure medical treatment. I understand that the covered to whom this authorization is directed may not condition medical treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my workers' compensation and health records may include information relating to (a) psychiatric, psychological, or mental health information, and (b) to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.**

Name of Worker	Name of Worker's Representative (if applicable)
Former/Alias/Maiden Name of Worker	Description of Authority to Act for Worker
Address of Worker	Signature of Worker or Representative
Date	

Exhibit "D"

[Authorization for Release of Disability Claims Records]

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Form Approved
OMB No. 0960-0566

Consent for Release of Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

*My Full Name	*My Date of Birth (MM/DD/YYYY)	*My Social Security Number

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**
Medical Research Consultants

***ADDRESS OF PERSON OR ORGANIZATION:**
1336 Brittmoore Road, Suite 100
Houston, Texas 77043

***I want this information released because:** Litigation

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. [X] Verification of Social Security Number
2. [ ] Current monthly Social Security benefit amount
3. [ ] Current monthly Supplemental Security Income payment amount
4. [ ] My benefit or payment amounts from date _____ to date _____
5. [X] My Medicare entitlement from date _____ to date _____
6. [X] Medical records from my claims folder(s) from date_____ to date_____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. [X] Complete medical records from my claims folder(s)
8. [X] Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   Application for SSD and all documents related to the determination for eligibility including any consultative exams, reports, or documents submitted during the appeals process.

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Exhibit “E”

[Authorization for Release of Educational Records]

LIMITED AUTHORIZATION TO DISCLOSE EDUCATIONAL INFORMATION

(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03 and the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99))

In re: Social Media Adolescent Addiction/Personal Injury Products Liability Litigation
Case No. 4:22-MD-03047-YGR, MDL No. 3047
United States District Court for the Northern District of California

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Student/Patient | Date of Birth | Social Security Number

This will authorize you to furnish to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas 77043,** complete copies of the following records and/or information for the time period from _____ to the present:

All educational records and information (including those that may contain protected health information) regarding the individual identified by name, DOB, and Social Security number above, including, but not limited to, the following: application and admission documentation; attendance records; report cards; grades or transcripts; standardized testing and other testing results; placement and other evaluations; honors; awards; diplomas; athletic letters; extra-curricular activities; health and physical examination records; immunization records; nurse's notes and records; guidance counselor's notes and records; social worker's notes and records; other counseling notes or records; disciplinary records (including suspensions or expulsions); letters of recommendation; other correspondence; and any and all other information and records.

1. To records provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing, please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.**

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas 77043**. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this educational/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure educational admissions, benefits, or accommodations, or to assure medical treatment. I understand that the entity to whom this authorization is directed may not condition medical treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 34 CFR § 99.30(c) and/or 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my educational and health records may include information relating to (a) psychiatric, psychological, or mental health information, and (b) to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.**

Name of Student	Name of Student's Representative (if applicable)
Former/Alias/Maiden Name of Student	Description of Authority to Act for Student
Address of Student	Signature of Student or Representative
Date	

Exhibit “F”

[Authorization for Release of Insurance Information]

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION

In re: Social Media Adolescent Addiction/Personal Injury Products Liability Litigation
Case No. 4:22-MD-03047-YGR, MDL No. 3047
United States District Court for the Northern District of California

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Insured | Date of Birth | Social Security Number

This will authorize you to furnish to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas 77043,** complete copies of the following records and/or information for the time period from _____ to the present:

All applications for insurance coverage and renewals; all insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage or claims; all physicians, hospitals, psychiatric, psychological, and dental reports, prescriptions, correspondence, test results, radiology, and any other medical reports and records that were submitted for claims review purposes; any claim record filed; records of any claim paid; records of all litigation; and any other records of any kind concerning or pertaining to the insured.

1. To records provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing, please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.**

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas**

77043. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this insurance/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure insurance coverage, insurance benefits, or to assure medical treatment. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my insurance and health records may include information relating to (a) psychiatric, psychological, or mental health information, and (b) to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.**

Name of Insured	Name of Insured's Representative (if applicable)
Former/Alias/Maiden Name of Insured	Description of Authority to Act for Insured
Address of Insured	Signature of Insured or Representative
Date	

Exhibit “G”

[Authorization for Release of Medicaid Information]

AUTHORIZATION FOR RELEASE OF MEDICAID INFORMATION

In re: Social Media Adolescent Addiction/Personal Injury Products Liability Litigation
Case No. 4:22-MD-03047-YGR, MDL No. 3047
United States District Court for the Northern District of California

To: _____
Name

_____
Address

_____
City, State and Zip Code

Re: _____ _____ _____
Name of Individual | Date of Birth | Social Security Number

This will authorize you to furnish to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas 77043,** complete copies of the following records and/or information for the time period from _____ to the present:

All Medicaid records, including explanations of Medicaid benefit records and claims records; any statements, communications, pro reviews, denials, appeals, correspondence, reports, questionnaires or records submitted in connection with claims; all reports from physicians, hospitals, dental providers, prescriptions; correspondence, test results and any other medical records; records of claims paid to or on the behalf of the individual identified by name, DOB, and Social Security number above; records of litigation and any other records of any kind. I expressly request that all covered entities under HIPAA identified above disclose full and complete protected medical information.

1. To records provider: **This authorization is being forwarded by, or on behalf of, attorneys for the purpose of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition with any individual in connection with providing these records. Subject to all applicable legal objections, this restriction does not apply to discussing these matters at a deposition or trial. Because this litigation is ongoing, please take all steps necessary to preserve all original records, information and tangible things related to the above-named person.**

2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to **Medical Research Consultants, 1336 Brittmoore Road, Suite 100, Houston, Texas 77043**. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my

insurance company when the law provides my insurer with the right to contest a claim under my policy.

3. Unless otherwise revoked, this authorization will expire in two years.

4. I understand that authorizing the disclosure of this Medicaid/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure Medicaid coverage, Medicaid benefits, or to assure medical treatment. I understand that the covered entity to whom this authorization is directed may not condition medical treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR § 164.524. I understand that protected health information (PHI) disclosed pursuant to this authorization may be subject to redisclosure by the recipients and that, in such case, the disclosed PHI no longer will be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

5. A notarized signature is not required. A copy of this authorization may be used in place of an original.

6. This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof.

7. **I understand that the information in my Medicaid and health records may include information relating to (a) psychiatric, psychological, or mental health information, and (b) to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I understand that by signing this authorization I am agreeing that this protected information will be released.**

Name of Individual	Name of Individual's Representative (if applicable)
Former/Alias/Maiden Name of Individual	Description of Authority to Act for Individual
Address of Individual	Signature of Individual or Representative
Date	

Exhibit “H”

[Medicare Authorization to Disclose Personal Health Information Form]

Medicare

Beneficiary Services:1-800-MEDICARE (1-800-633-4227)
TTY/ TDD:1-877-486-2048

This form is used to advise Medicare of the person or persons you have chosen to have access to your personal health information.

Where to Return Your Completed Authorization Forms:
After you complete and sign the authorization form, return it to the address below:

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

For New York Medicare Beneficiaries ONLY
The New York State Public Health Law protects information that reasonably could identify someone as having HIV symptoms or infection, and information regarding a person's contacts. Because of New York's laws protecting the privacy of information related to alcohol and drug abuse, mental health treatment, and HIV, there are special instructions for how you, as a New York resident, should complete this form.

- For question 2A, check the box for *Limited Information*, even if you want to authorize Medicare to release any and all of your personal health information.

- **Then proceed to question 2B.**

Instructions for Completing Section 2B of the Authorization Form:
Please select one of the following options.

- **Option 1** To **include** all information, in the space provided, write: "all information, including information about alcohol and drug abuse, mental health treatment, and HIV". Proceed with the rest of the form.

- **Option 2** To **exclude** the information listed above, write "Exclude information about alcohol and drug abuse, mental health treatment and HIV" in the space provided. *You may also check any of the remaining boxes and include any additional limitations in the space provided.* For example, you could write "payment information". Then proceed with the rest of the form.

If you have any questions or need additional assistance, please feel free to call us at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Sincerely,

1-800-MEDICARE
Customer Service Representative

Encl.

Information to Help You Fill Out the "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in the privacy notice contained in the Medicare & You handbook. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

If you want 1-800-MEDICARE to give your personal health information to someone other than you, you need to let Medicare know in writing.

If you are requesting personal health information for a deceased beneficiary, please include a copy of the legal documentation which indicates your authority to make a request for information. (For example: Executor/Executrix papers, next of kin attested by court documents with a court stamp and a judge's signature, a Letter of Testamentary or Administration with a court stamp and judge's signature, or personal representative papers with a court stamp and judge's signature.) Also, please explain your relationship to the beneficiary.

Please use this step by step instruction sheet when completing your "1-800-MEDICARE Authorization to Disclose Personal Health Information" Form. Be sure to complete all sections of the form to ensure timely processing.

1. Print the name of the person with Medicare.

   Print the Medicare number exactly as it is shown on the red, white, and blue Medicare card, including any letters (for example, 123456789A).

   Print the birthday in month, day, and year (mm/dd/yyyy) of the person with Medicare.

2. This section tells Medicare what personal health information to give out. Please check a box in 2a to indicate how much information Medicare can disclose. If you only want Medicare to give out limited information (for example, Medicare eligibility), also check the box(es) in 2b that apply to the type of information you want Medicare to give out.

3. This section tells Medicare when to start and/or when to stop giving out your personal health information. Check the box that applies and fill in dates, if necessary.

4. Medicare will give your personal health information to the person(s) or organization(s) you fill in here. You may fill in more than one person or organization. If you designate an organization, you must also identify one or more individuals in that organization to whom Medicare may disclose your personal health information.

5. The person with Medicare or personal representative must sign their name, fill in the date, and provide the phone number and address of the person with Medicare.

   If you are a personal representative of the person with Medicare, check the box, provide your address and phone number, and attach a copy of the paperwork that shows you can act for that person (for example, Power of Attorney).

6. Send your completed, signed authorization to Medicare at the address shown here on your authorization form.

7. If you change your mind and don't want Medicare to give out your personal health information, write to the address shown under number six on the authorization form and tell Medicare. Your letter will revoke your authorization and Medicare will no longer give out your personal health information (except for the personal health information Medicare has already given out based on your permission).

You should make a copy of your signed authorization for your records before mailing it to Medicare.

1-800-MEDICARE Authorization to Disclose Personal Health Information

Use this form if you want 1-800-MEDICARE to give your personal health information to someone other than you.

1. **Print Name** (First and last name of the person with Medicare) _____ **Medicare Number** (Exactly as shown on the Medicare Card) _____ **Date of Birth** (mm/dd/yyyy) _____

2. Medicare will only disclose the personal health information you want disclosed.

   2A: **Check only <u>one</u> box below to tell Medicare the specific personal health information you want disclosed:**

   ☐ Limited Information (go to question 2b)

   ☐ Any Information (go to question 3)

   2B: **Complete <u>only</u> if you selected "limited information". Check all that apply:**

   ☐ Information about your Medicare eligibility

   ☐ Information about your Medicare claims

   ☐ Information about plan enrollment (e.g. drug or MA Plan)

   ☐ Information about premium payments

   ☐ Other Specific Information (please write below; for example, payment information)

   _____

3. **Check only <u>one</u> box below indicating how long Medicare can use this authorization to disclose your personal health information** (subject to applicable law—for example, your State may limit how long Medicare may give out your personal health information):

   ☐ Disclose my personal health information indefinitely

   ☐ Disclose my personal health information for a specified period only
   beginning: (mm/dd/yyyy) _____ and ending: (mm/dd/yyyy) _____

4. Fill in the name and address of the person(s) or organization(s) to whom you want Medicare to disclose your personal health information. Please provide the specific name of the person(s) for any organization you list below:

1. Name: Medical Research Consultants

   Address: 1336 Brittmoore Road, Suite 100

   Houston, Texas 77043

2. Name: _____

   Address: _____

   _____

3. Name: _____

   Address: _____

   _____

5.

I authorize 1-800-MEDICARE to disclose my personal health information listed above to the person(s) or organization(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) or organization(s) and may no longer be protected by law.

_____ _____ _____

Signature Telephone Number Date (mm/dd/yyyy)

Print the address of the person with Medicare (Street Address, City, State, and ZIP)

_____

_____

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (for example, Power of Attorney). This only applies if someone other than the person with Medicare signed above.

Print the Personal Representative's Address (Street Address, City, State, and ZIP)

_____

_____

Telephone Number of Personal Representative: _____

Personal Representative's Relationship to the Beneficiary: _____

6. **Send the completed, signed authorization to:**

Medicare BCC, Written Authorization Dept.
PO Box 1270
Lawrence, KS 66044

7. **Note:**

You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Medicare has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above.

Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, eligibility for benefits, or the amount Medicare pays for the health services you receive.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0930**. The time required to complete this information collection is estimated to average **15 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.